Mental Health Hospital Level of Care Application Form

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And members of the advisory committee

Introduction

This form enables a child to apply for an institutional level of care (ILC). This care can be delivered through the home and community-based services/severe emotional disturbance (HCBS/SED) waiver or through a state hospital. It is divided into three major parts; ***each part must be completed based upon a face-to-face interview with the child and family member(s) as well others means of gathering information such as medical records***.

Part 1: Identifying information. This portion of the ILC application contains sections for you to provide contact information for the child seeking services, his or her parent or guardian, and the child's case worker(s).

Part 2: Assessment information. This portion of the application contains questions that help determine the child's eligibility for services.

Part 3: Attachments. Some of the attachments are required with every ILC application; others are used only if an exception is requested for a child who would otherwise not qualify for services.

To qualify for services, a child must:

1. Be at least age 4 and under age 18; an exception is possible for youth, ages 18 through 21.
2. Meet the Severe Emotional Disturbance (SED) criterion; **there is no exception**.
3. Have a minimum score of 70 on two subscales of the appropriate version of the Achenbach System of Empirically Based Assessment (ASEBA): **All versions can be viewed and purchased at www.aseba.org.**
   - Child Behavior Checklist for ages 1½-5 (CBCL/1½ -5)
   - Caregiver-Teacher Report Form for ages 1½ -5 (C-TRF)
   - Child Behavior Checklist for ages 6-18 (CBCL/6-18)
   - Teacher's Report Form for ages 6-18 (C-TRF)
   - Youth Self-Report for ages 6-18 (YSR)
4. Have an average item score on the Hoosier Assurance Plan Instrument – Children & Adolescents (HAPI-C) of less than or equal to 3.5 on any two listed factors; **there is no exception.**
5. Have received intermediate community-based services (ICBS). These services are defined as any one or combination of targeted case management, day treatment, or home-based therapy; an exception is possible for those who do not meet this criterion.

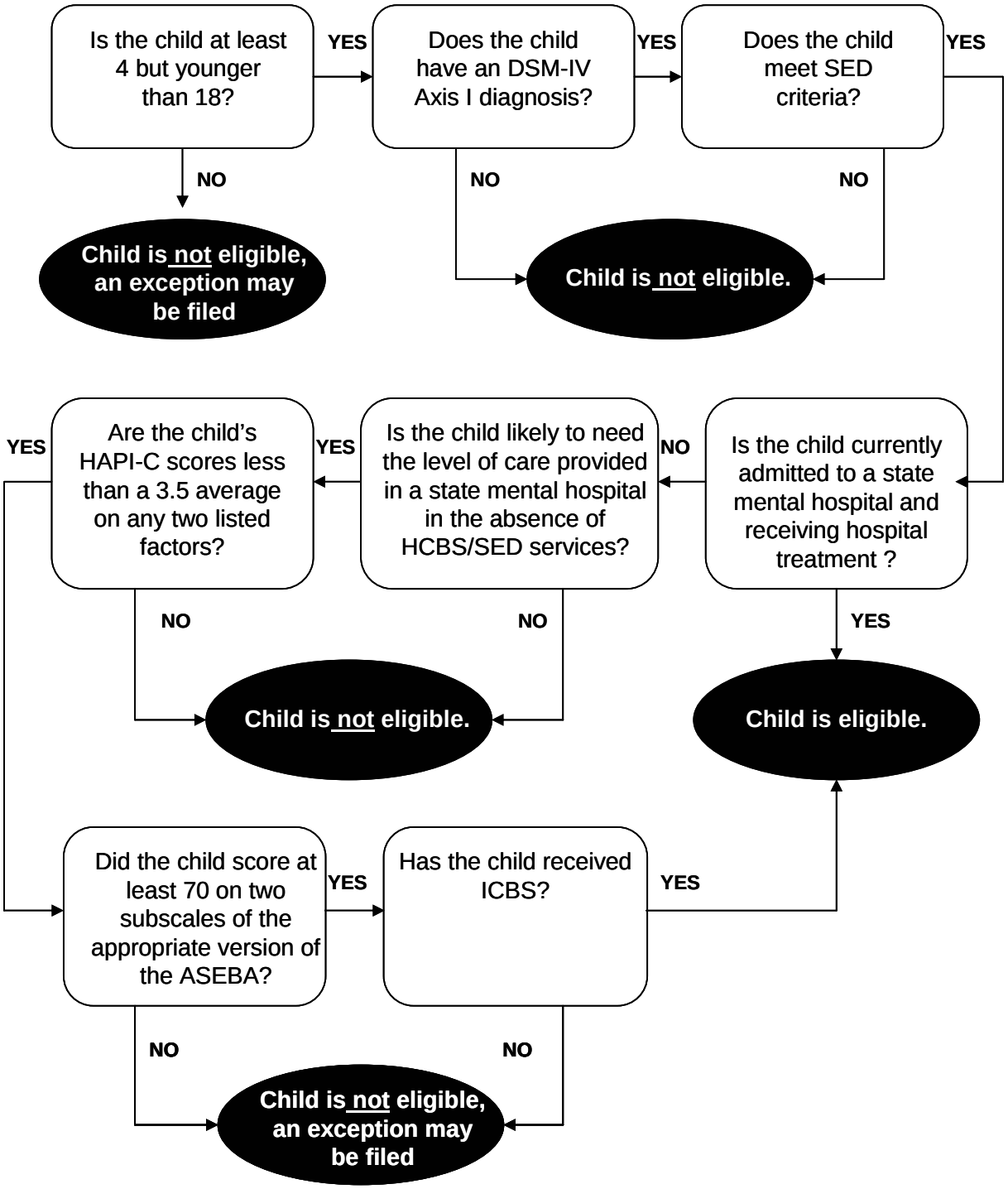
Eligibility for individuals meeting the criteria can be determined at the community mental health center (CMHC); decisions about exceptions for children who do not meet the criteria in items numbers 1, 3 and 5 must be determined at the state level for admission into the (HCBS/SED) waiver program but may be determined at the CMHC for admission into the state hospital.

The graphic on the next page depicts the decision flow for determining whether a child is eligible for an institutional level of care. **Eligibility for services does not necessarily mean space is available.**

Maintain the original application form and supporting documentation at the CMHC. If an HCBS/SED waiver is requested, forward a copy of the completed application form, along with all relevant attachments, to:

HCBS/SED Waiver Manager
Office of Transitional Services, DMHA
402 W. Washington Street, W353
Indianapolis, IN 46204

Decision Flow for Determining Child's Eligibility for an Institutional Level of Care



Institutional Level of Care Application Form: Initial Clinical Eligibility

Type of Service Requested: ❑ Treatment within a state hospital ❑ An HCBS/SED waiver

PART 1. IDENTIFYING INFORMATION

Child's Identifying Information

Name:	(Last)	(First)	(MI)
Also Known As:	(Last)	(First)	(MI)
Also Known As	(Last)	(First)	(MI)
Date of Birth:	__ __ /__ __ /__ __ __ __	**Sex:** ❑ Male ❑ Female	
Preferred Language of Communication: ❑ English ❑ Spanish ❑ Other:			
Current Address:	❑ Home ❑ Treatment Setting ❑ Homeless (NO street address) ❑ Other:		
(Street)			
(City)		(State)	(Zip)
Telephone number:	( )		
Education/Vocation status:			

Referral Source

Name:	(Last)	(First)	(MI)
Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Email Address:		**Telephone Number:**	( )

Parent/Guardian Identifying Information:

Name:	(Last)	(First)	(MI)
Relationship to child: ❑ Parent ❑ Guardian ❑ Grandparent ❑ Aunt/Uncle ❑ Other:			
Preferred Language of Communication: ❑ English ❑ Spanish ❑ Other:			
Current Address:	❑ Home ❑ Treatment Setting ❑ Homeless (NO street address) ❑ Other:		
(Street)			
(City)		(State)	(Zip)
Telephone number:	( )		

CHINS/Ward Custody? ❑ **NO** ❑ **YES** Case Number: _____

Case Worker Identifying Information (if applicable)

Name:	(Last)	(First)		(MI)
Address:	(Street)			
(City)		(County	(State)	(Zip)
Email Address:		**Telephone Number:**	( )	

Probation Officer Identifying Information (if applicable)

Name:	(Last)	(First)		(MI)
Address:	(Street)			
(City)		(County	(State)	(Zip)
Email Address:		**Telephone Number:**	( )	

PART 2. ASSESSMENT INFORMATION

1. Is the child at least 4 years but not yet 18 years old?

❑ **NO** (Go to number 9. To request an exception for youth ages 18 to 21, complete Attachment C)

❑ **YES** (Go to number 2.)

2. Does the child have a current DSM-IV, Axis I diagnosis? (Substance abuse diagnosis alone not sufficient.)

❑ **NO** (Child is not eligible. Go to number 9.)

❑ **YES** (Fill out the information below. Then go to number 3.)

Code numbers of primary diagnoses: _____

Date of most recent diagnosis: _____

Psychiatrist or HSPP psychologist making the diagnoses:

Name and credentials: _____

License number: _____

Agency: _____

Telephone number: ( )

Assessment Information (cont)

3. Does the child meet Severe Emotional Disturbance (SED) criterion?

❑ **NO** (Child is not eligible. Go to number 9.)

❑ **YES** (Fill out the information below. Then go to number 4)

Date of determination of SED: __ __/__ __ /__ __ __ __ (Determination must be within last 365 days)

Mental health professional making the SED determination

Name and credentials: _____

Agency: _____

Telephone number: ( )

4. Is the child currently admitted to a state mental health hospital and receiving hospital treatment services?

❑ **NO** (Go to number 5.)

❑ **YES** (Child is eligible for ILC. Attach copy of hospital service plan. Complete Attachment A. Then go to number 9.)

5. Is the child likely to need the level of care provided in a state mental health hospital in the absence of HCBS/SED services?

❑ **NO** (Child is not eligible for ILC. Go to number 9.)

❑ **YES** (Complete Attachments A and B. Then go to number 6.)

6. Record the results of the Hoosier Assurance Plan Instrument – Children and Adolescents (HAPI-C).

Date of HAPI-C: __ __/__ __ /__ __ __ __ *(Evaluation must be within last 30 days.)*

Indicate item averages:

• Affective Symptoms (average of items 1, 2, 3)		• School (average of items 13, 14, 15, 16)	
• Suicidal ideation/behaviors (score of item 4)		• Disruptive behaviors (average of items 17, 18, 19)	
• Thinking (average of items 8, 9)		• Substance abuse/use (average of items 20, 21, 22)	
• Family (average of items 10, 11, 12)		• Reliance on mental health services (score of item 24)	

Did the child score less than or equal to an average of 3.5 on each of two listed factors?

❑ **NO** (Child is not eligible for the ILC. Go to number 9.)

❑ **YES** (Go to number 7.)

Item #6 (cont)

Mental health professional completing the HAPI-C:

Name and credentials: _____

Agency: _____

Telephone number: ( )

7. Record results of the appropriate version of the ASEBA.

*Date of the CBCL,*TRF,*YSR,* CBCL/1½ -5, or C-TRF: __ __/__ __ /__ __ __ __ *(Scores must be within last 30 days.)*

Indicate scores on the version used:

SUBSCALES	CBCL 6-18 Scores	TRF 6-18 Scores	YSR 6-18 Scores	**SUBSCALES**	CBCL 1½-5 Scores	C-TRF 1½-5 Scores
Anxious/Depressed				*Emotionally Reactive*		
Withdrawn/Depressed				Anxious/Depressed		
Social Problems				*Withdrawn*		
Thought Problems				*Attention Problems*		
Attention Problems				*Aggressive Behavior*		
Rule-Breaking Behavior						
Aggressive Behavior						
Total Problems				**Total Problems**		

Did the child score at least 70 on two subscales? (e.g. Withdrawn, Anxious/Depressed, Thought Problems, etc.)

❑ **NO** (Child is not eligible for ILC. Go to number 9. If desired, you may apply for an exception.)

❑ **YES** (Go to number 8.)

Mental health professional scoring the ASEBA:

Name and credentials: _____

Agency: _____

Telephone number: ( )

Assessment Information (cont)

8.	Has child received intermediate community based services (ICBS)? ICBS is defined as any one or combination of the following CMHC-provided services: Targeted Case Management, Day Treatment, or Home Based Therapy. Complete Attachment E. **(Outpatient therapy or non-community mental health services are not considered ICBS.)** ❑ **NO** Child is not eligible for ILC. (Refer to ICBS or apply for an exception.) ❑ **YES** (Go to number 9)

9.	Select all that apply:	
	Child **is** eligible for ILC.	❑ Treatment is requested at a state hospital. ❑ Treatment is requested through the HCBS/SED Waiver. (Go to number 10.)
	Child is **not** eligible for ILC but exceptions are approved by the CMHC for treatment at a **state hospital.**	❑ Age 18 criterion (Complete Attachment C.) ❑ ASEBA scores (Complete Attachment D.) ❑ ICBS criterion (Complete Attachment E.) **Keep the application and all attachment on file at the CMHC.**
	Child is **not** eligible for ILC but exceptions are being requested through the state for treatment through the **HCBS/SED Waiver.**	❑ Age 18 criterion (Complete Attachment C.) ❑ ASEBA scores (Complete Attachment D.) ❑ ICBS criterion (Complete Attachment E.) **Forward the application and all attachment to the HCBS/SED Waiver Manager.** **(Hold the Notice of Action and then go to number 10 if the exceptions are denied.)**
	Child is **not** eligible for ILC.	❑ Exceptions were not requested. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Exceptions were denied. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Child does not meet HAPI-C criterion. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Child does not need the level of care provided by a state mental health hospital. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Child did not attain a t-score of 63-69 on the ASEBA. **(Go to number 11 for HCBS/SED ineligibility.)**

Assessment Information (cont)

10.	What date was the Notice of Action delivered informing the child and family/caretaker that the child **does not** meet the eligibility criteria for the **HCBS/SED** waiver? (Go to number 12.)	__ __/__ __/__ __ __ __
11.	If the Notice of Action indicated that the child does not meet **HCBS/SED** eligibility criteria, on what date was the parent/guardian notified that an appeals process exists? (Go to number 13.)	__ __/__ __/__ __ __ __
12.	What date was the appeal: ❑ Filed (Go to number 13.) ❑ Declined (Go to *Prepared by* section.)	__ __/__ __/__ __ __ __
13.	What date was the appeal: ❑ Approved ❑ Denied (Go to *Prepared by* section.)	__ __/__ __/__ __ __ __

Persons Interviewed Face-to-Face: ❑ Child ❑ Family Members (list below)

(Printed name):	Date:
(Signature):	Telephone number: ( )
(Printed name):	Date:
(Signature):	Telephone number: ( )
(Printed name):	Date:
(Signature):	Telephone number: ( )

I certify that community-based care is ☐ safe and feasible ☐ not safe or feasible in regard to the health and safety of the child/youth. (If not safe or feasible, explain on signed separate sheet.)

Prepared By: ☐QMHP ☐Physician

(Printed name):	Date:
(Signature):	Telephone number: ( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		
Level of Care Authorization	☐ Initial ☐ Update ☐ Annual ☐ Approved ☐ Disapproved Effective Medicaid Reimbursement Date:		
Date	Authorized Signature ☐ Initial IFSSA/OMPP ☐ Annual CMHC QMHP		

ATTACHMENT A: SUMMARY OF CMHC CLINICAL ASSESSMENT

(Include additional pages as necessary)

Child's Name: _____ **Date:** __ __/__ __/__ __ __ __

1. List the locations where child currently receives services. Specify the state mental health hospital, community health or child service providers:

Location	*Date Admitted:* M M / D D / Y Y Y Y

2. List the community services that have been provided. List services provided for the past six months.

Service	*Start Date* M M / D D / Y Y Y Y	*End Date* M M / D D / Y Y Y Y	*Frequency*	*Providers*
Targeted Case Mgmt				
Day Treatment				
Home-Based Therapy				

3. List the acute services that have been provided. List services provided for the past three months.

Service	*Start Date* M M / D D / Y Y Y Y	*End Date* M M / D D / Y Y Y Y	*Frequency*	*Providers*

Attachment A (cont)

4.	Provide a summary of the clinical findings regarding the child's need for institutional level of care. The documentation should be behaviorally focused and include the following items:
	Symptoms:
	Medications/Reason prescribed (may attach list) :
	Presenting Problems:
	Relevant Medical Information:
	Risk Factors:
	Clinical Impressions:
	Strengths and Resources Available to Child (e.g. family, education, spiritual, ability, etc):
	GAF Score: *Current:* __ __ *Highest level of functioning in past year:* __ __

Attachment A (cont)

5.	Provide a summary of the clinical findings regarding the child's prognosis with provision of institutional level of care:	
	Expectation for child with waiver services:	
	Expectation for child without waiver services:	
	Anticipated length of stay:	
	Transition services (family/caregiver):	

Prepared By:

(Printed name):		Date:
(Signature):	Telephone number: ( )	

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

ATTACHMENT B: CURRENT EVIDENCE SUPPORTING CHILD'S NEED FOR LEVEL OF CARE PROVIDED IN A STATE MENTAL HEALTH HOSPITAL

(Include additional pages as necessary)

Child's Name: _____ **Date:** __ __/__ __/__ __ __ __

1.	Describe the **specific** behaviors/problems that would prevent the child from remaining in their home without HCBS/SED services. Be sure to list **examples** of aggressive behaviors, assaultive behaviors, self-mutilation, animal cruelty, substance abuse, risky sexual behavior, etc.)

2.	Describe the child's family and current living situation that supports the need for HCBS/SED services. Be sure to be specific. D*o* not use general phrases. Describe in detail.

3.	Describe the factors in the child's school/vocational placement that support the need for HCBS/SED services. (e.g. aggressive behavior, reduced school day due to behavior problems, failed efforts to mainstream with assistance, difficulty remaining on task in self contained classroom, significantly below achievement level, formally identified as E.H. or S.E.H., previously applied for assistance from Department of Education, etc.) Describe in detail.

4.	Describe private outpatient therapy and non-clinical interventions and the extent to which they have or have not been successful in treating the child. (e.g. family and other support systems, YMCA services, church services etc.*)*

Prepared By:

(Printed name):			Date:
(Signature):		Telephone number: ( )	
Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

ATTACHMENT C: REQUEST FOR EXCEPTION TO AGE 18 CRITERION

(Include additional pages as necessary)

Youth's Name: _____ **Date:** __ __/__ __/__ __ __ __

1. Does the youth have a current DSM-IV, Axis I diagnosis? (Substance use diagnosis alone not sufficient.)

❑ **NO** (Youth is not eligible. (Go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES** (Fill out the information below. Then go to number 2 on this attachment.)

Code numbers of primary diagnoses: _____

Date of most recent diagnosis: _____

Psychiatrist or HSPP psychologist making the diagnoses:

Name and credentials: _____

License number: _____

Agency: _____

Telephone number: ( )

2. Does the youth meet Seriously Mentally Ill (SMI) criterion?

❑ **NO** (Youth is not eligible. (Go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES** (Fill out the information below. Then go to number 3 on this attachment.)

Date of determination of SMI: __ __/__ __ /__ __ __ __ (Determination must be within last 365 days)

Mental health professional making the SMI determination:

Name and credentials: _____

Agency: _____

Telephone number: ( )

3. Is the youth currently admitted to a state mental health hospital and receiving hospital treatment services?

❑ **NO** (Go to number 4 on this attachment.)

❑ **YES** (Youth is eligible for ILC. Attach copy of hospital service plan. Complete Attachment A. Then go to number 9 on the *Initial Clinical Eligibility* form.)

Attachment C (cont)

4. Is the youth likely to need the level of care provided in a state mental health hospital in the absence of ILC services?

❑ **NO** (Youth is not eligible for ILC. (Go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES** (Complete Attachments A and B. Then go to number 5 on this attachment.)

5. Record the results of the Hoosier Assurance Plan Instrument – Adults (HAPI-A).

Date of HAPI-A: __ __/__ __ /__ __ __ __ *(Evaluation must be within last 30 days.)*

Indicate item averages:

• Symptoms of Distress and Mood (average of items A, B, C)		• Risk Behavior and Substance Abuse (average of items M, N1, N2, N3, N4, N5, N6)	
• Community Functioning (average of items E, F, G, H)		• Reliance on Mental Health Services (score of item O)	
• Social Support-Skills and Housing (average of items I, J, K, L)			

Did the youth score less than or equal to an average of 3.5 on each of two listed factors?

❑ **NO** Youth is not eligible for ILC. (Go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES** Fill in the information requested on who completed the HAPI-A. (Then go to number 6 on this attachment.)

Mental health professional completing the HAPI-A:

Name and credentials: _____

Agency: _____

Telephone number: ( )

Attachment C (cont)

6. Record results of the ASEBA Adult Self-Report for ages 18-59 (ASR) or the Adult Behavior Checklist for Ages 18-59 (ABCL).

Date of ASR or ABCL: __ __/__ __ /__ __ __ __ *(Scores must be within last 30 days.)*

Indicate scores on the version used:

SUBSCALES	ASR Scores	ABCL Scores
Anxious/Depressed		
Withdrawn		
Thought Problems		
Attention Problems		
Aggressive Behavior		
Rule-Breaking Behavior		
Intrusive		
Total Problems		

Did the youth score at least 70 on two subscales? (e.g. Withdrawn, Somatic Complaints etc.)

❑ **NO** Youth is not eligible for ILC. Fill in the information requested on who completed the ABCL/ASR. (Go to number 9 on the *Initial Clinical Eligibility* form. If desired, you may apply for an exception.)

❑ **YES** Fill in the information requested on who completed the ABCL/ASR. (Go to number 7 on this attachment.)

Mental health professional scoring the ABCL, or ASR:

Name and credentials: _____

Agency: _____

Telephone number: ( )

7. Has ICBS been in place and continually provided to the youth at least six months prior to the date of the current clinical eligibility assessment? NOTE: Intermediate Community Based Service (ICBS) is defined as any one or combination of the following CMHC provided services: Targeted Case Management, Day Treatment, or Home Based Therapy ONLY. *Do not include outpatient therapy or non-CMHC services.*

❑ **NO**. Youth does not meet ILC criteria. (To apply for an exception, go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES**. (Go to item 8 on this attachment.)

Attachment C (cont)

8.	List the community services that have been provided. List services provided for the past six months.				
	Service	*Start Date* M M / D D / Y Y Y Y	*End Date* M M / D D / Y Y Y Y	*Frequency*	*Providers*
	Targeted Case Mgmt				
	Day Treatment				
	Home-Based Therapy				

Comments: Describe other circumstances to be considered in waiving the age 18 criterion.

Prepared By:

(Printed name):	Date:
(Signature):	Telephone number: ( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

Exception Decision:

❑ **Granted**	❑ **Denied**	**Decision Date** __ __ **/** __ __ **/** __ __ __ __
Authorized by:	(Name and Title)	
Telephone Number:	( )	

ATTACHMENT D: REQUEST FOR EXCEPTION TO ASEBA CRITERION

(Include additional pages as necessary)

Child's Name: _____ **Date:** __ __/__ __/__ __ __ __

1. Was a t-score of 63 -69 attained for the child on *Total Problems*?

- ❑ **NO** Child does not meet ILC criteria. (Go to number 9 on the *Initial Clinical Eligibility* form.)
- ❑ **YES** (Document reasons for ASEBA exception in number 2 below.)

2. Explain why the ASEBA minimum score criterion should be excepted. For example, describe circumstances that interfere with attaining the minimum ASEBA score, or clinical observations that support exception of the minimum score. (e.g. language barrier, cultural values/beliefs, etc) Go to number 3 below.

3. Has an ASEBA been completed in the **6 months previous to this current clinical assessment** that attained a score of 70 or higher?

- ❑ **NO** ASEBA not previously administered. (Be sure to check with schools before marking this box.)
- ❑ **NO** ASEBA administered by score was less than 70. **Date completed:** __ __ /__ __ /__ __ __ __
- ❑ **YES** ASEBA administered and score was greater than 70. **Date completed:** __ __ /__ __ /__ __ __ __

Mental health professional scoring the ASEBA was:

Name and credentials: _____

Agency: _____

Telephone number: ( )

Attachment D (cont)

Prepared By:

(Printed name):	Date:
(Signature):	Telephone number: ( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

Exception Decision:

❑ **Granted** ❑ **Denied**	**Decision Date** __ __ **/** __ __ **/** __ __ __ __
Authorized by:	(Name and Title)
Telephone Number:	( )

ATTACHMENT E: REQUEST FOR EXCEPTION TO ICBS CRITERION
(Use additional pages as necessary)

Child's Name: _____ **Date:** __ __/__ __/__ __ __ __

1.	Document barriers to obtaining intermediate community based services (ICBS). (e.g. financial difficulties, services unavailable in the community, child in residential care, group home, DOC, etc.)

2.	Describe other circumstances to be considered to support need for HCBS/SED waiver or admission to a state hospital even though ICBS have not been provided to the child and family. Please be specific.

Attachment E (cont)

Prepared By:

(Printed name):	Date:
(Signature):	Telephone number: ( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

Exception Decision:

❑ **Granted**	❑ **Denied**	**Decision Date** __ __ **/** __ __ **/** __ __ __ __
Authorized by:	(Name and Title)	
Telephone Number:	( )	